No. 2
5-43

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 23 1948

Registration District No. 114

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5432

State File No. 12070

Registrar's No. 59

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: Franklin

(b) City or town: Rural Meramec Twsp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Sullivan, Mo. Rt. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1
In this community: 2 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Franklin 36 0

(c) City or town: Rural
(If outside city or town limits, write "RURAL") 0

(d) Street No.: Sullivan, Mo. Rt. 2.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country: U

3. (a) PRINT FULL NAME: Rosy Belle Brewer

3. (b) If veteran, name war: No.

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Harvey Brewer

6. (c) Age of husband or wife if alive: 57 years

7. Birth date of deceased: Nov. 9 (Month) 1894 (Year)

8. AGE: Years	Months	Days	If less than one day
53	5	4	hr. min.

9. Birthplace: Owensville (City, town, or county) Mo. U (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: Home

MOTHER / FATHER

12. Name: Isaac Bunton 9

13. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER

14. Maiden name: Nevada Carroll 9

15. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant: Harvey Brewer

(b) Address: Sullivan, Mo. Rt. 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/16/48 (Month) (Day) (Year)

(c) Place: burial or cremation: Fee Fee Cem. St. Louis County, Mo.

18. (a) Signature of funeral director: [illegible]

(b) Address: 65 N. Clark Ave. Sullivan, Mo.

19. (a) 4-15-48 (Date received local registrar) (b) C.A. Boston (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13
year 1948 hour 6 minute 20 A.M.

21. I hereby certify that I attended the deceased from March 13 1948 to Apr. 12 1948
that I last saw her alive on Apr. 12 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 hours
Due to: Essential Hypertension	3 years
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: (30)	
Of autopsy: 0	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury: 7

23. Signature: Dr. H. L. Kelley (M.D. or other) D.O.

Address: Sullivan Mo. Date signed 4/16/48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed APR 22 1948

MAY 15 1950

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~ .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address Sullivan, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. No. 2B
M—3-45
1 X43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. M 04

Registration District No. 114 Primary Registration District No. 5432 Registrar's No. 59

1. **PLACE OF DEATH:**
(a) County Franklin
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. **USUAL RESIDENCE OF DECEASED:**
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Roy B. Brewer
3. (b) If veteran, name war 0
3. (c) Social Security No. 1

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Nov. 9 (Month) (Day) (Year)

8. **AGE:** Years 63 Months 5 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 4-15-48 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month January 13 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-12070